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7 Attorneys for Complainant

8 **BEFORE THE**  
**BOARD OF REGISTERED NURSING**  
9 **DEPARTMENT OF CONSUMER AFFAIRS**  
10 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:

Case No. 2009-247

12 **SHEILA ANTOINETTE BENNETT**  
1036 Raisher  
13 St. Louis, MO 63180

**A C C U S A T I O N**

14 Registered Nurse License No. 664960

15 Respondent.

16  
17 Complainant alleges:

18 **PARTIES**

19 1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation  
20 solely in her official capacity as the Executive Officer of the Board of Registered Nursing  
21 ("Board"), Department of Consumer Affairs.

22 2. On or about September 2, 2005, the Board issued Registered Nurse  
23 License Number 664960 to Sheila Antoinette Bennett ("Respondent"). Respondent's registered  
24 nurse license expired on June 30, 2007.

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1 CAUSE FOR DISCIPLINE

2 (Disciplinary Action by the Arizona State Board of Nursing)

3 7. Respondent is subject to disciplinary action pursuant to Code section  
4 2761, subdivision (a)(4), on the grounds of unprofessional conduct. On or about May 28, 2008,  
5 pursuant to the Consent for Entry of Voluntary Surrender Order No. 0704091 ("Voluntary  
6 Surrender"), accepted by the Arizona State Board of Nursing, in the disciplinary proceeding titled  
7 *In the Matter of Professional Nurse License No. RN137215 Issued to: Sheila Antoinette Bennett*,  
8 Respondent voluntarily surrendered her license to practice registered nursing in the State of  
9 Arizona. A true and correct copy of the Voluntary Surrender is attached as **Exhibit "A"** and  
10 incorporated herein by reference. The Arizona Board's discipline was based upon the following  
11 admissions by Respondent:

12 a. From on or about February 12, 2007, to March 9, 2007, while employed as  
13 a registered nurse at Carondelet St. Mary's Hospital Extended Care Unit, a Behavioral Health  
14 Unit, in Tucson, Arizona, Respondent did the following:

15 i. On or about March 6, 2007, Respondent refused to administer  
16 patient C.K.'s 2:00 p.m. scheduled medications at 3:30 p.m. Respondent reportedly told C.K.  
17 that she was unable to administer the scheduled medications at 2:00 p.m. because C.K. was on  
18 the telephone and therefore was not going to administer them at a later time (3:30 p.m.).  
19 According to Respondent, patient C.K. wanted her 2:00 p.m. scheduled medications past the  
20 "legal" time for administering medications, one hour before and one hour past the scheduled  
21 administration time. Respondent said C.K. had received medications "multiple times that day"  
22 and she informed the oncoming shift C.K. had not received her 2:00 p.m. medications.

23 ii. From on or about February 26, 2007, through 12:00 p.m. on March  
24 7, 2007, a review of the Medication Administrative Records for Carondelet St. Mary's Hospital  
25 Extended Care Unit revealed Respondent made multiple medication errors. The errors included  
26 failure to administer medications, administering medications over an hour late, documenting  
27 medication administration inaccurately, administering the higher dose of medication for anxiety

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1 without documenting why the lower dose ordered was not administered, and failing to document  
2 patient's blood pressure before administering an antihypertensive medication.

3           b.       From on or about June 11, 2007, to July 3, 2007, while employed as a  
4 registered nurse at HCR Manor Care of Tucson in Tucson, Arizona, Respondent did the  
5 following:

6                   i.       From on or about June 11, 2007, Respondent reportedly was  
7 uncooperative and insubordinate with the HCR Manor Care Director of Nursing and the charge  
8 nurses. Staff made numerous complaints about Respondent failing to administer and/or  
9 document administration of medications and failure to complete other assigned responsibilities.

10                   ii.       On or about June 25, 2007, Respondent documented she had  
11 administered medications. However, photos taken of pre-poured medications in Respondent's  
12 assigned medication cart indicated that she had not administered the medications. On or about  
13 October 2, 2007, in an interview with Board staff, Respondent denied she pre-poured  
14 medications.

15                   iii.       On or about July 2, 2007, Respondent was reportedly rude and  
16 verbally aggressive toward resident S.B. According to resident S.B., when she told Respondent  
17 that her medications were always given by mouth, not by injection Respondent said, "You'll get  
18 what I give you." Resident S.B. reported when she refused the injection, Respondent "shot the  
19 medication into the air and rammed the needle of the syringe into the wall." On or about October  
20 2, 2007, in an interview with Board staff, Respondent denied she shot the medication into the air  
21 and that she rammed the needle into the wall.

22           c.       The conduct and circumstances described in subsections (a) and (b) above  
23 constitute violations of A.R.S. § 32-1663 (D) as defined in § 32-1601(16)(d) and (j); and A.A.C.  
24 R4-19-403 (B), (1), (8), (9), and (31) (adopted effective November 15, 2005).

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1 P R A Y E R


2 WHEREFORE, Complainant requests that a hearing be held on the matters herein  
3 alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

4 1. Revoking or suspending Registered Nurse License Number 664960, issued  
5 to Sheila Antoinette Bennett;

6 2. Ordering Sheila Antoinette Bennett to pay the Board of Registered  
7 Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to  
8 Business and Professions Code section 125.3; and

9 3. Taking such other and further action as deemed necessary and proper.

10  
11 DATED: 4/13/09

12   
13 RUTH ANN TERRY, M.P.H., R.N.  
14 Executive Officer  
15 Board of Registered Nursing  
16 Department of Consumer Affairs  
17 State of California  
18 Complainant  
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**EXHIBIT A**

**VOLUNTARY SURRENDER**

ARIZONA STATE BOARD OF NURSING  
4747 North 7th Street, Suite 200  
Phoenix, Arizona 85014-3653  
602-889-5150

08 MAY 27 AM 10:16

IN THE MATTER OF PROFESSIONAL  
NURSE LICENSE NO. RN137215  
ISSUED TO:

SHEILA ANTOINETTE BENNETT  
RESPONDENT

CONSENT FOR ENTRY OF  
VOLUNTARY SURRENDER  
ORDER NO. 0704091

A complaint charging Sheila Antoinette Bennett ("Respondent") with violation of the Nurse Practice Act has been received by the Arizona State Board of Nursing ("Board"). In the interest of a prompt and speedy settlement of the above-captioned matter, consistent with the public interest, statutory requirements, and the responsibilities of the Board, and pursuant to A.R.S. §2-1663 (D)(5), Respondent voluntarily surrenders her license for a minimum of five years.

Based on the evidence before it, the Board makes the following Findings of Fact, Conclusions of Law:

**FINDINGS OF FACT**

1. Respondent holds Board issued professional nurse license no. RN137215.
2. From or about February 12, 2007 to March 9, 2007, Respondent worked as a registered nurse at Carondelet St. Mary's Hospital Extended Care Unit, a Behavioral Health Unit, in Tucson, Arizona.
3. On or about March 6, 2007, Respondent refused to administer patient C.K.'s 2:00 pm scheduled medications at 3:30 p.m. Respondent reportedly told C.K. that she was unable to administer the scheduled medications at 2:00 p.m. because C.K. was on the telephone and therefore was not going to administer them at a later time (3:30 pm). According to Respondent, patient C.K. wanted her 2:00

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p.m. scheduled medications past the "legal" time for administering medications, one hour before and one hour past the scheduled administration time. Respondent said C.K. had received medications "multiple times that day" and she informed the on coming shift C.K. had not received her 2:00 p.m. medications.

4. From or about February 26, 2007 through 12:00 p.m. on March 7, 2007, a review of the Medication Administrative Records for Carondelet St. Mary's Hospital Extended Care Unit revealed Respondent made multiple medication errors. The errors included failure to administer medications, administering medications over an hour late, documenting medication administration inaccurately; administering the higher dose of medication for anxiety without documenting why the lower dose ordered was not administered, and failing to document patients' blood pressure before administering an antihypertensive medication.

5. From or about June 11, 2007 to July 3, 2007, Respondent worked as a registered nurse at HCR Manor Care of Tucson in Tucson, Arizona.

6. From or about June 11, 2007, Respondent reportedly was uncooperative and insubordinate with the HCR Manor Care Director of Nursing and the charge nurses. Staff made numerous complaints about Respondent failing to administer and/or document administration of medications and failure to complete other assigned responsibilities.

7. On or about June 25, 2007, Respondent documented she had administered medications. However, photos taken of pre-poured medications in Respondent's assigned medication cart indicate that she had not administered the medications. On or about October 2, 2007, in an interview with Board staff, Respondent denied she pre-poured medications.

8. On or about July 2, 2007, Respondent was reportedly rude and verbally aggressive toward resident S.B. According to resident S.B., when she told Respondent that her medications were

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always given by mouth, not by injection. Respondent said, "You'll get what I give you." Resident S.B. reported when she refused the injection, Respondent "shot the medication into the air and rammed the needle of the syringe into the wall." On or about October 2, 2007, in an interview with Board staff, Respondent denied she shot the medication into the air and that she rammed the needle into the wall.

9. On or about March 22, 2008, Respondent requested to voluntarily surrender her license.

#### CONCLUSIONS OF LAW

Pursuant to A.R.S. §§ 32-1606, 32-1663, and 32-1664, the Board has subject matter and personal jurisdiction in this matter.

The conduct and circumstances described in the Findings of Fact constitute a violation of A.R.S. § 32-1663 (D) as defined in § 32-1601 (16), (d) and (j), and A.A.C. R4-19-403 (B), (1), (8), (9), and (31) (adopted effective November 15, 2005).

The conduct and circumstances described in the Findings of Fact constitute sufficient cause pursuant to A.R.S. §§ 32-1663(D) (5) 32-1664(N) to take disciplinary action against Respondent's license to practice as a professional nurse in the State of Arizona.

Respondent admits the Board's Findings of Fact, Conclusions of Law.

Respondent understands that she has an opportunity to request a hearing and declines to do so. Respondent agrees to issuance of the attached Order and waives all rights to a hearing, rehearing, appeal, or judicial review relating to this Order.

Respondent understands that all investigative materials prepared or received by the Board concerning these violations and all notices and pleadings relating thereto may be retained in the Board's file concerning this matter.

Respondent understands that the admissions in the Findings of Fact are conclusive evidence of a violation of the Nurse Practice Act and may be used for purposes of determining sanctions in any

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future disciplinary matter.

Respondent understands the right to consult legal counsel prior to entering into the Consent Agreement and such consultation has either been obtained or is waived.

Respondent understands that this voluntary surrender is effective upon its acceptance by the Executive Director or the Board and by Respondent as evidenced by the respective signatures thereto. Respondent's signature obtained via facsimile shall have the same effect as an original signature. Once signed by the Respondent, the agreement cannot be withdrawn without the Executive Director or the Board's approval or by stipulation between the Respondent and the Executive Director or the Board. The effective date of this Order is the date the Voluntary Surrender is signed by the Executive Director or the Board and by Respondent. If the Voluntary Surrender is signed on a different date, the later date is the effective date.

Respondent understands that Voluntary Surrender constitutes disciplinary action. Respondent also understands that she may not reapply for reinstatement during the period of Voluntary Surrender.

Respondent agrees that she may apply for reinstatement after the period of voluntary surrender under the following conditions, and must comply with current law at the time of their application for reinstatement:

The application for reinstatement must be in writing and shall contain therein or have attached thereto substantial evidence that the basis for the voluntary surrender has been removed and that the reinstatement of the license does not constitute a threat to the public's health, safety and welfare. The Board may require physical, psychological, or psychiatric evaluations, reports and affidavits regarding

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the Respondent as it deems necessary. These conditions shall be met before the application for reinstatement is considered.

Sheila Bennett  
Respondent: Sheila Antoinette Bennett

Date: 4-20-08

ARIZONA STATE BOARD OF NURSING

SEAL

Joey Ridenour  
Joey Ridenour, R.N., M.N., F.A.A.N.  
Executive Director

Dated: 5/28/08

Twigg/Bennett

ORDER

Pursuant to A.R.S. § 32-1663 (D) (5) the Board hereby accepts the Voluntary Surrender of professional nurse license number RN137215, issued to Sheila Antoinette Bennett. This Order of Voluntary Surrender hereby entered shall be filed with the Board and shall be made public upon the effective date of this Consent Agreement. Respondent shall not practice in Arizona under the privilege of a multistate license.

IT IS FURTHER ORDERED that Respondent may apply for reinstatement of said license after a period of five years.

ARIZONA STATE BOARD OF NURSING

SEAL

Joey Ridenour  
Joey Ridenour, R.N., M.N., F.A.A.N.  
Executive Director

Dated: 5/28/08

JR/nlt:

2 VOUCHERS TO  
REGISTERED NURSING  
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COPY mailed this 3<sup>rd</sup> day of April 2008, by First Class Mail to:

Sheila Antoinette Bennett  
1036 Raisher  
St. Louis, MO 63130

By: Trina Smith  
Legal Secretary

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